Pattern of Tobacco Use Among Women and Girls

CIGARETTE SMOKING PREVALENCE AMONG WOMEN

- Cigarette smoking was rare among women in the early 20th century. Cigarette smoking became prevalent among women after it did among men, and smoking prevalence has always been lower among women than among men. However, the gender-specific difference in smoking prevalence narrowed between 1965 and 1985. Since 1985, the decline in prevalence among men and women has been comparable.

- Smoking prevalence decreased among women from 33.9% in 1965 to 22.0% in 1998. Most of this decline occurred from 1974 through 1990; prevalence declined very little from 1992 through 1998.

- The prevalence of current smoking is three times higher among women with 9-11 years of education (32.9%) than among women with 16 or more years of education (11.2%).

- Smoking prevalence is higher among women living below the poverty level (29.6%) than among those living at or above the poverty level (21.6%).

CIGARETTE SMOKING AMONG RACIAL/ETHNIC POPULATIONS OF WOMEN

- In 1997-1998, 34.5% of American-Indian or Alaska-Native, 23.5% of white, 21.9% of African-American, 13.8% of Hispanic, and 11.2% Asian/Pacific-Islander women were current smokers.

- Among white women and African-American women, smoking prevalence decreased from 1965 through 1998. The prevalence of current smoking was generally comparable, but from 1970 through 1985 it was higher — some years significantly so — among African-American women. In 1990, it was higher among white women.

- From 1965 through 1998, the decline in smoking prevalence among Hispanic women was significantly less than among white and African-American women.

- Among Asian-American or Pacific-Islander women, smoking prevalence decreased from 1979 through 1992, but then increased from 1995 through 1998. Prevalence changed little from 1979 through 1998 among American-Indian or Alaska-Native women.

CIGARETTE SMOKING AMONG GIRLS AND YOUNG WOMEN

- Among high school senior girls, past-month current smoking rates decreased from 39.9% in 1977 to 25.8% in 1992, but increased to 35.3% during 1997. In 2000, smoking prevalence declined again to 29.7%.

- Much of the progress in reducing smoking prevalence among girls in the 1970s and 1980s was lost with the increase in prevalence in the 1990s. Current smoking rates among high school senior girls were the same in 2000 as in 1988.

- In the late 1970s and early 1980s, the prevalence of smoking among high school seniors was higher among girls than among boys, but the decline in smoking prevalence from 1976 through 1992 was more rapid among girls than among boys. Since the mid-1980s, smoking prevalence among girls and boys has been similar.

- From 1991 to 1996, current smoking prevalence in the past 30 days increased from 13.1% to 21.1% among 8th grade girls but decreased to 14.7% in 2000. Among 10th grade girls, current smoking prevalence in the past 30 days increased from 20.7% in 1991 to 31.1% in 1997, but decreased to 23.6% in 2000.

- Aggregated data from 1976-1977 through 1991-1992 showed a dramatic decline in past-month cigarette smoking among African-American high school senior girls (from 37.5% to 7.0%) compared with the decline among white girls (from 39.9% to 31.2%). From 1991-1992 through 1997-1998, past-month smoking prevalence increased among white girls (from 31.2% to 41.0%) and African-American girls (from 7.0% to 12.0%) — but the increase was statistically significant only among white girls.

- In 1990-1994, smoking prevalence for high school senior girls was highest among American-Indians or Alaska-Natives (39.4%) and whites (33.1%) and lowest among Hispanics (19.2%), Asian-Americans or Pacific-Islanders (13.8%), and African-Americans (8.6%).

- Smoking among young women (aged 18 through 24 years) declined from 37.3% in 1965-1966 to 25.1% in 1997-1998. However, recent trends show that smoking rates in this population may be rising.

- In 1998, nearly 14 million women of reproductive age were smokers, and smoking prevalence in this group was higher (25.3%) than in the overall population of women aged 18 years or older (22.0%).

CIGARETTE SMOKING AMONG PREGNANT WOMEN

- Despite increased knowledge of the adverse health effects of smoking during pregnancy, survey data suggest that a substantial number of pregnant women and girls smoke. However, cigarette smoking during pregnancy declined from 19.5% in 1989 to 12.9% in 1998.

- Smoking prevalence during pregnancy differs by age and by race and ethnicity. In 1998, smoking prevalence during pregnancy was consistently highest among young adult women aged 18 through 24 (17.1%) and lowest among women aged 25 through 49 (10.5%).

- Smoking during pregnancy declined among women of all racial/ethnic populations. From 1989 to 1998, smoking among American-Indian or Alaska-Native pregnant women decreased from 23.0% to 20.2%; among pregnant white women from 21.7% to 16.2%; African-American pregnant women from 17.2% to 9.6%; Hispanic pregnant women from 8.0% to 4.0%; and Asian-American or Pacific-Islander pregnant women from 5.7% to 3.1%.

- In 1998, there was nearly a 12-fold difference by the educational status among pregnant women who smoked — ranging from 25.5 percent among mothers with 9-11 years of education to 2.2 percent among mothers with 16 or more years of education.

NICOTINE DEPENDENCE

- The level of nicotine dependence is strongly associated with the quantity of cigarettes smoked per day.

- When results are stratified by the number of cigarettes smoked per day, girls and women who smoke appear to be equally dependent on nicotine, as measured by first cigarette after waking, smoking for a calming and relaxing effect, withdrawal symptoms, or other measures of nicotine dependence.

- Of the women who smoke, more than three-fourths report one or more indicators of nicotine dependence, and nearly three-fourths report feeling dependent on cigarettes.

QUITTING SMOKING AND ATTEMPTS TO QUIT

- More than three-fourths (75.2%) of women want to quit smoking completely, and nearly half (46.6%) report having tried to quit during the previous year.

- In 1998, the percentage of people who had ever smoked and who had quit was lower among women (46.2%) than among men (50.9%). This finding may be because men began to stop smoking earlier in the 20th century than did women and because these data do not take into account that men are more likely than women to switch to, or to continue to use, other tobacco products when they stop smoking.

- Since the late 1970s or early 1980s, the probability of attempting to quit smoking and succeeding has been equal among women and men.

OTHER TOBACCO USE

- The use of cigars, pipes, and smokeless tobacco among women is generally low, but recent data suggest that cigar smoking among women and girls is increasing.

- A California study found that current cigar smoking among women increased five-fold from 1990 through 1996.

- The prevalence of cigar use appears to be higher among adolescent girls than among women. In 1999, past-month cigar use among high school girls younger than 18 was 9.8%.

- The prevalence of pipe smoking among women is low, and women are much less likely than men to smoke a pipe.

- The prevalence of smokeless tobacco use among girls and women is low and remains considerably lower than that among boys and men.

- For tobacco use other than cigarettes among high school girls, cigar use is the most common, bidi and kretek use are intermediate, and pipe and smokeless tobacco use are the least common.

Efforts to Reduce Tobacco Use Among Women and Girls

SMOKING CESSATION

- There are numerous effective smoking cessation methods available in the United States. The methods range from self-help materials, to intensive clinical approaches, to broad community-based programs. Minimal clinical assistance; intensive clinical assistance; and individual, group, or telephone counseling have shown few differences in effectiveness between men and women.

- Studies show no major or consistent differences between women's and men's motivation to quit, readiness to quit, general awareness of the harmful health effects of smoking, or the effectiveness of intervention programs for tobacco use.

- Based on national surveys, the probability of attempting to quit smoking and to succeed has been equally high among women and men since late 1970s or early 1980s.

SELF-HELP INTERVENTIONS

- The majority of smokers who try to stop using tobacco reported doing so on their own, even though this is the least effective method. This pattern has changed somewhat in recent years with increased use of pharmacologic aids.

MINIMAL CLINICAL INTERVENTIONS

- The likelihood of having been counseled to stop smoking was slightly higher for women (39%) than for men (35%); women report more physician visits than men, which allows more opportunity for counseling.

INTENSIVE CLINICAL INTERVENTIONS

- Intensive clinical interventions involve individual, group, or telephone counseling for multiple sessions. The most successful treatments are multi-component cognitive behavioral programs that incorporate strategies to prepare and motivate smokers to stop smoking.

- Women are somewhat more likely than men to use intensive treatment programs. Similarly, women have a stronger interest than men in smoking cessation groups that offer mutual support through a buddy system and in treatment meetings over a long period.

PHARMACOLOGIC INTERVENTIONS

- A number of effective pharmacotherapies for nicotine addiction have emerged in the past decade — nicotine gum and nicotine patch (approved for over-the-counter use), nicotine nasal spray, oral nicotine inhaler, and Bupropion (available by prescription). Two other pharmacotherapies, Clonidine and the antidepressant Nortiptyline, have been recommended as second-line pharmacotherapies, but have not yet been approved by the Food and Drug Administration for this indication — smoking cessation.

- Pharmacologic approaches to smoking cessation raise a number of issues specific to women. Nevertheless, nicotine replacement has been shown to be more effective than placebo among women smokers and, thus, remains recommended for use.

- More research is needed to determine the effects of nicotine replacement therapy on pregnant women and their offspring.

SMOKING CESSATION ISSUES UNIQUE TO WOMEN

- Studies have identified numerous gender-related factors that should be studied as predictors for smoking cessation, as well as factors for continued smoking or relapse after quitting. These factors include hormonal influences, pregnancy, fear of weight gain, lack of social support, and depression.

- Women stop smoking more often during pregnancy — both spontaneously and with assistance — than at any other time in their lives. However, most women return to smoking after pregnancy: up to 67% are smoking again by 12 months after delivery.

- Pregnancy-specific programs benefit both maternal and infant health and are cost-effective. If the national prevalence of smoking before or during the first trimester of pregnancy were reduced by one percentage point annually, it would prevent 1,300 babies from being born at low birth weight and save $21 million (in 1995 dollars) in direct medical costs in the first year alone. Prenatal smoking cessation interventions can be of economic benefit to healthcare insurers.

- More women than men fear weight gain if they quit smoking; however, few studies have found a relationship between weight gain concerns and smoking cessation among either women or men. Further, actual weight gain during cessation efforts does not predict relapse to smoking.

- Smoking cessation treatment and social support derived from family and friends improve cessation rates. It is inconclusive whether there are gender differences in the role of social support on long-term smoking cessation.

SMOKING CESSATION AMONG WOMEN OF LOW SOCIOECONOMIC STATUS

- Women of low socioeconomic status (SES) have lower rates of smoking cessation than do women of higher SES. Studies that analyze the effects of mass media campaigns suggest that smokers of low SES, especially women, are more likely than smokers of high SES to watch and obtain cessation information from television.

- Women of low SES enrolled in intensive cessation intervention programs (stress management, self-esteem enhancement, group support, and other activities that improve quality of life) have 20%–25% successful cessation rates. Unfortunately, only a small proportion of women of low SES appear to take advantage of these programs.

SMOKING CESSATION AMONG WOMEN FROM RACIAL AND ETHNIC POPULATIONS

- In general, African-American, Hispanic, and American-Indian or Alaska-Native women want to stop smoking at rates similar to those of white women, but there is little research on smoking cessation among women in racial/ethnic minority populations.

INCREASING THE UNIT PRICE FOR TOBACCO PRODUCTS

- There is strong scientific evidence that shows increases in state and federal excise taxes on tobacco products reduce consumption and increase the number of people who stop using tobacco. Price increases reduce consumption of tobacco products by adults, young adults, adolescents, and children.

MASS-MEDIA EDUCATION CAMPAIGNS

- Mass-media campaigns implemented in combination with other interventions, such as excise tax increases and community education programs are effective in reducing tobacco consumption and motivating tobacco product users to quit.

REDUCING THE COST OF CESSATION SERVICES TO SMOKERS

- There are a number of effective interventions to help tobacco-users in their efforts to quit, such as behavioral programs offering counseling in individual or group settings and the use of a number of pharmacotherapies, including nicotine replacement. One way to increase the use of effective treatments is to lower the cost for people who wish to use these treatments. Scientific evidence shows that interventions that reduce smokers' costs (such as programs that reduce or eliminate the insured's co-payment) increase the number of people who stop using tobacco products.

  - There is no Medicare coverage for tobacco use dependence except in a few states that will participate in a demonstration project beginning in April 2001.

  - Six states provide Medicaid coverage for counseling, and four states cover all prescription drugs and over-the-counter nicotine replacement products.

  - Under private insurance, 42% of managed care organizations (MCOs) cover counseling, 16% cover indemnity counseling, 38% cover drugs, and 25% cover indemnity drugs.